UF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 12/05/20 STATEMENT OF DEFICIENCIES FORM APPROVI (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-03 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 445373 B. WING NORTHSIDE HEALTH CARE NURSING AND REHABILITATION C STREET ADDRESS, CITY, STATE, ZIP CODE 11/30/2017 202 EAST MTCS ROAD (X4) ID PREFIX MURFREESBORO, TN 37130 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) TAG CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE DEFICIENCY) F 000 INITIAL COMMENTS This plan of correction constitutes a written F 000 allegation of substantial compliance with A recertification survey and complaint Federal and Medicaid requirements and state investigation #42717, #42878, #42882, #42907, requirements when necessary #42910 were completed on 11/28/17-11/30/17 at Northside Health Care Nursing and Rehabilitation F550 Center. No deficiencies were cited related to complaint investigation #42717, #42907, and 1. #42910. Deficiencies were cited related to the a. Residents #15 was recertification survey and complaint investigations offered appropriate #42878 and #42882 under 42 CFR PART 483, utensils during meal Requirements for Long Term Care Facilities. times and offered Resident Rights/Exercise of Rights F 550 assistance periodically CFR(s): 483.10(a)(1)(2)(b)(1)(2) SS=D F 550 throughout meal on 11/30/17. 11/30/17 §483.10(a) Resident Rights. b. All residents The resident has a right to a dignified existence, (including 16 and 35) self-determination, and communication with and requiring assistance access to persons and services inside and were ensured to be outside the facility, including those specified in assisted timely by adding 2 additional staff members to assist §483.10(a)(1) A facility must treat each resident with meals as of with respect and dignity and care for each 11/30/17 resident in a manner and in an environment that DON and ADON did 100% audit promotes maintenance or enhancement of his or of residents in the dining area her quality of life, recognizing each resident's 3. All nursing start will be reindividuality. The facility must protect and educated on Resident Rights and 11/30/17 promote the rights of the resident. Dining Services policies by 12/29/17. New Employees will be §483.10(a)(2) The facility must provide equal educated upon hire before entering access to quality care regardless of diagnosis, 12/29/17 patient care areas. severity of condition, or payment source. A facility DON, ADON, and other must establish and maintain identical policies and designee to do 2x weekly audits of practices regarding transfer, discharge, and the dining areas and dining practices for provision of services under the State plan for all 6 weeks. Any findings of 01/26/18 residents regardless of payment source. noncompliance will be presented to the QAPI committee for review. §483.10(b) Exercise of Rights. LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that LNAA

other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued FORM CMS-2567(02-99) Previous Versions Obsolete

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		445373	B WING			11/30/2017	
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	rights as a resident or resident of the U §483.10(b)(1) The resident can exerci interference, coerci from the facility. §483.10(b)(2) The free of interference reprisal from the farights and to be supexercise of his or his or his or his or his regular to preserve the required feeding as #16, #35) of 23 resident to the facili including Diabetes I Fibrillation, Obstruction Fibromyalgia. Medical record review admitted to the facili including Diabetes I Fibrillation, Obstruction Fibromyalgia. Medical record review Data Set (MDS) data #15 scored 10 on the Status (BIMS), indicating cognitive impairment MDS revealed Resident record review of the status (BIMS), indicating the score of the sco	the right to exercise his or her tof the facility and as a citizen United States. facility must ensure that the ise his or her rights without ion, discrimination, or reprisal resident has the right to be a coercion, discrimination, and icility in exercising his or her ported by the facility in the iter rights as required under this NT is not met as evidenced tion and interview, the facility he dignity of residents who is istance for 3 residents (#15, idents observed for dining.	F 5	50			
	toileting						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			ONSTRUCTION	((X3) DATE SURVEY COMPLETED	
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F 550	Continued From pa	, i	F	550				
	Resident #15 was uto not having a spoout of the bowl. Coshe spilled pudding smeared on her face	28/17 at 12:42 PM revealed unable to eat her pudding due on so she licked the pudding ntinued observation revealed on her clothing and had it be. Several staff members t #15 and failed to offer					No. of the last of	
Medical record review revealed Resident #16 was admitted to the facility on 9/17/15 with diagnoses including Parkinson's Disease, Chronic Pain, Dementia, and Transient Ischemic Attack.								
	dated 9/4/17 reveal impaired cognitively MDS revealed Res people for transfers	ew of the Quarterly MDS ed Resident #16 was severely // Continued review of the ident #16 was dependent on 2 if; was dependent on one if, eating, grooming, and						
	Resident #16 was s required feeding as Aide (CNA) fed one #16 was the last to food was uncovered	28/17 at 11:30 AM revealed seated at table for 4 who sistance. The Certified Nurse resident at a time. Resident be assisted with eating; the d while other residents were the food was not reheated isted with eating.						
	Resident #16 was sassisted one reside the last to be assist sleepy. Observation uncovered while 3 co	29/17 at 8:10 AM revealed seated at a table. The CNA nt at a time. Resident #16 was ed with eating and was a revealed the food remained other residents were assisted to not reheated. Continued						

PRINTED: 12/05/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING 445373 R WING 11/30/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 202 EAST MTCS ROAD NORTHSIDE HEALTH CARE NURSING AND REHABILITATION C MURFREESBORO, TN 37130 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) 1D (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 550 F 550 Continued From page 3 observation revealed the CNA sat in front of Resident #16 and put a spoon of food in the resident's mouth without saying anything to her. Further observation revealed Resident #16 was not waking up so the CNA assisted her with 3 bites then moved on to another resident. Medical record review revealed Resident #35 was admitted to the facility on 7/20/15 with diagnoses including Alzheimers, Diabetes Mellitus, and Chronic Obstructive Pulmonary Disease. Medical record review of the Quarterly MDS dated 4/10/17 revealed Resident #35 was severely impaired cognitively. Continued review of the MDS revealed Resident #35 required extensive assistance with transfers, dressing, grooming, bathing, eating, and toileting. Observation on 11/28/17 at 12:30 PM, revealed the lunch tray was placed on the table at 11:30 AM. Resident #35 did not eat until her son came to assist her with eating at 12:10 PM. Observation revealed the food was not reheated before the resident was assisted with eating. Observation on 11/29/17 at 8:00 AM revealed breakfast trays arrived at 8:00 AM. Resident #35 was assisted with eating at 8:22 AM after 2 other residents were assisted. Continued observation revealed the food was not reheated before the resident was assisted with eating.

Interview with the Director of Nursing (DON) on 11/30/17 at 1:50 PM in her office confirmed it was not acceptable to fail to assist a resident who has food on their face and clothing. Continued interview with the DON confirmed residents should not be made to wait for their meals and

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NORTH		URSING AND REHABILITATION	IG	STREET ADDRESS, CITY, STATE, ZIP CODE 202 EAST MTCS ROAD MURFREESBORO, TN 37130	1 11	/30/2017
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S S S S S S S S S S S S S S S S S S S	the food should be resident. Self-Determination CFR(s): 483.10(f)(1): §483.10(f) Self-deter The resident has the promote and facilitate through support of re- not limited to the right (1) through (11) of this §483.10(f)(1) The resident activities, schedules (in waking times), health care services consiste assessments, and plate applicable provisions of (483.10(f)(2) The resident choices about aspects acility that are significate through support of re- not limited to the right (1) through (11) of this care services consiste assessments, and plate applicable provisions of (483.10(f)(3) The resident through (1) the resident acility. 483.10(f)(8) The resident deriticipate in other activities be acility. 483.10(f)(8) The resident deriticipate in other activities activities and community terfere with the rights of cility. assed on observation a led to allow 1 resident	eheated before assisting the (3)(8) mination. right to and the facility must a resident self-determination sident choice, including but as specified in paragraphs (f) as section. ident has a right to choose including sleeping and care and providers of health ent with his or her interests, in of care and other of this part. Ident has a right to make of his or her life in the ant to the resident. Ident has a right to interact formunity and participate in oth inside and outside the ent has a right to not of other residents in the sand must be so that a sevidenced and intension the factories.	F 550		nted their ne by ry, to r y d	11/29/17 11/29/17 12/29/17

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	The findings included Observation on 11/2 PM in the main dinin #11 was seated at a meal. Continued obsinteraction with staff Observation on 11/2 revealed Resident # alone eating breakfarevealed she had no residents. Interview with Resident # alone eating breakfarevealed she had no residents. Interview with Resident # alone eating breakfarevealed she had no residents. Interview with Resident # alone eating breakfarevealed she had no residents during din was at a table all alowants to sit with me confirmed the residents during din Interview with the Alat 8:10 AM in the m why Resident #11 w stated, "She used to lady died." Continue facility used a seating we can deliver the totale." Further intervialled to offer Residents for stafe/Clean/Comfort.	during breakfast and lunch. 28/17 from 11:25 AM-12:05 ng room revealed Resident a table alone eating the lunch servation revealed she had no for other residents. 29/17 from 7:30 AM-8:05 AM 211 was seated at a table ast. Continued observation o interaction with staff or other lent #11 on 11/29/17 at 8:07 ng room when asked why she one stated, "I guess nobody ." Continued interview ent would like to sit with other ing. ctivities Director on 11/29/17 ain dining room when asked as seated alone for dining o sit with someone but the ad interview revealed the ag chart for the residents "so rays at one time to each view confirmed the facility ent #11 the choice to sit with ocial interaction during dining able/Homelike Environment	F 56				
	§483.10(i) Safe Env						

Facility ID: TN7506

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Th §4 ho us po (i) reconstruction (ii) the or §4 see an §4 lev §4 lev \$4 lev \$9 81	t not limited to reports for daily live facility must prosent and in the facility must prosent and in the facility must prosent and in the facility shall a protection of the facility shall a	melike environment, including ceiving treatment and ving safely. ovide- e, clean, comfortable, and ent, allowing the resident to onal belongings to the extent suring that the resident can ervices safely and that the refacility maximizes resident does not pose a safety risk, exercise reasonable care for a resident's property from loss ekeeping and maintenance to maintain a sanitary, orderly,	F 584	1. Resident #9's wheelch cleaned to remove debr sanitized for infection of 11/30/17. 2. 100% Audit of all whee throughout the building were cleaned and sanitineeded on 12/13/17. 3. All staff will be re-educ Resident's Rights and to importance of a clean, environment. Staff will educated on a revised of schedule on 12/13/17. 4. Audits of resident areas equipment to be compleweek by the managemed during Guardian Angel weeks. Any findings of noncompliance will be the QAPI committee for	is and control on elchairs and they zed as cated on he homelike also be cleaning and team Rounds for 6 f presented to	11/30/17 12/13/17 12/13/17 01/26/18	

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NAME OF PROVIDER OR SUPPLIER NORTHSIDE HEALTH CARE NURSING AND REHABILITATION C (X4) ID PREFIX (LACK DEFICIENCY MUST BE PRECEDED BY FULL TAG) TAG (LACK) DEPICIENCY MUST BE PRECEDED BY FULL TAG) F 584 Continued From page 7 Based on observation and interview, the facility failed to maintain a wheelchair in a sanitary manner for 1 resident (#52) of 37 residents reviewed. The findings included: Observation on 11/28/17 at 9:14 AM revealed Resident #9 seated in a wheelchair in the doorway of his room. Further observation revealed the left side of the wheel chair frame had multiple areas of dried brown debris. Interview with Licensed Practical Nurse #2 on 11/30/17 at 11:20 AM revealed Resident #9 seated in a wheelchair in the dining room at the dining room table. Further observation revealed the left side of the wheelchair frame had multiple areas of dried brown debris. Interview with Licensed Practical Nurse #2 on 11/30/17 at 11:21 AM by Resident #9's wheelchair in the main dining room confirmed the wheel chair in the main dining room confirmed the wheel chair in the main dining room confirmed the wheel chair main dining room confirmed the wheel chair in the main dining room confirmed the wheel chair in the main dining room confirmed the wheel chair in the main dining room confirmed the wheel chair in the main dining room confirmed the wheel chair in the main dining room confirmed the wheel chair in the main dining room confirmed the wheel chair in the main dining room confirmed the wheel chair in the main dining room confirmed the wheel chair in the main dining room confirmed the wheel chair in the main dining room confirmed the wheel chair in the main dining room confirmed the wheel chair in the main dining room confirmed the wheel chair in the main din	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A BUILDING		11.	TE SURVEY MPLETED
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F 584 Continued From page 7 Based on observation and interview, the facility failed to maintain a wheelchair in a sanitary manner for 1 resident (#52) of 37 residents reviewed. The findings included: Observation on 11/28/17 at 9:14 AM revealed Resident #9 seated in a wheelchair in the doorway of his room. Further observation revealed the left side of the wheel chair in the main dining room at the dining room table. Further observation revealed the left side of the wheelchair in the main dining room at the dining room table. Further observation revealed the left side of the wheelchair in the main dining room at the dining room table. Further observation revealed the left side of the wheelchair rame had multiple areas of dried brown debris. Interview with Licensed Practical Nurse #2 on 11/30/17 at 11:21 AM by Resident #9's wheelchair in the main dining room confirmed the wheel chair " was dirty That's disgusting" Interview and observation with the Director of Nursing on 11/30/17 at 2:05 PM in Resident #9's		URSING AND REHABILITATION	C 202 E	EAST MTCS ROAD		
Based on observation and interview, the facility failed to maintain a wheelchair in a sanitary manner for 1 resident (#52) of 37 residents reviewed. The findings included: Observation on 11/28/17 at 9:14 AM revealed Resident #9 seated in a wheelchair in the doorway of his room. Further observation revealed the left side of the wheel chair frame had multiple areas of dried brown debris. Observation on 11/28/17 at 11:09 AM, on 11/29/17 at 11:00 AM, and on 11/30/17 at 11:20 AM revealed Resident #9 seated in a wheelchair in the main dining room at the dining room table. Further observation revealed the left side of the wheelchair frame had multiple areas of dried brown debris. Interview with Licensed Practical Nurse #2 on 11/30/17 at 11:21 AM by Resident #9's wheelchair in the main dining room confirmed the wheel chair "was dirtyThat's disgusting" Interview and observation with the Director of Nursing on 11/30/17 at 2:05 PM in Resident #9's	PREFIX (EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	D BE	COMPLETION
resident's bathroom while the resident was in bed. Further interview revealed the wheelchair cleaning was done by rotation on the night shift and Resident #9's was scheduled for Sunday night. Further interview revealed the staff transferring a resident out of the wheelchair should wipe it down if it was dirty. Interview confirmed the dried brown debris on the cushion seat, under the cushion and along the left side of	Based on observation failed to maintain a manner for 1 resider reviewed. The findings include Observation on 11/2 Resident #9 seated doorway of his room revealed the left side had multiple areas of the main dining room for the main dining room further observation wheelchair frame has brown debris. Interview with License 11/30/17 at 11:21 AM in the main dining room chair "was dirtyT Interview and observe Nursing on 11/30/17 room revealed the woresident's bathroom bed. Further interview cleaning was done beand Resident #9's wanight. Further interview transferring a resider should wipe it down in confirmed the dried by	on and interview, the facility wheelchair in a sanitary int (#52) of 37 residents d: 8/17 at 9:14 AM revealed in a wheelchair in the . Further observation is of the wheel chair frame if dried brown debris. 8/17 at 11:09 AM, on 8/17 at 11:09 AM, on 1/1, and on 11/30/17 at 11:20 int #9 seated in a wheelchair om at the dining room table, revealed the left side of the id multiple areas of dried 1/2 deep Practical Nurse #2 on 1/3 by Resident #9's wheelchair om confirmed the wheel hat's disgusting 1/3 ration with the Director of at 2:05 PM in Resident #9's heelchair was stored in the while the resident was in w revealed the wheelchair y rotation on the night shift as scheduled for Sunday ew revealed the staff int out of the wheelchair fit was dirty. Interview brown debris on the cushion	F 584			

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED. IZUDIZUI CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVE STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-039 (X2) MULTIPLE CONSTRUCTION

AND PLAN OF	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) D	O. 0938-0: ATE SURVEY OMPLETED
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\$48 \$48 \$48 \$48 \$48 \$48 \$48 \$48 \$48 \$48	e resident has the glect, misapproprious of exploitation as a fludes but is not library punishment of poral punishment of the resident's not the resident not the	rom Abuse, Neglect, and e right to be free from abuse, riation of resident property, defined in this subpart. This mited to freedom from t, involuntary seclusion and nical restraint not required to nedical symptoms. ity mustare verbal, mental, sexual, or oral punishment, or if is not met as evidenced acility policy, medical record nicelity policy,	F 600	I. Residents #11 and #37 were immediately separated and as for injuries. No Injuries were a. Resident #37s Responder Party and doctor were notified on 11/6/17. Resident #37 was also to ER to be evaluated psychiatric treatment b. Resident #11s Responder Party and doctor were notified on 11/6/17. 2. DON and ADON interviewed staff involved in altercation about any opotential altercations that may have happened. Nursing Staff on duty continued to monitor all other residents for any potential altercations. Social Worker interviewed and observed residents to see if they had any report actions of altercations. 3. All staff were re-educated on the abuse policies including patient to patient altercations prior to enterin patient care environment. 4. Social Services to interview 3 residents weekly for any concerns abuse for 6 weeks. Management team will also ask residents during Guardian Angel Rounds if they had any concerns of abuse. Any finding of noncompliance will be presented to the QAPI committee for review.	found. consible e consent for disible ther ther conts of	11/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445373		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
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F 600	Disease, Cardiac A Type II, Anemia, G Disease, Difficulty and status-post Rig Continured medica quarterly Minimum 11/10/17 revealed with no moods or be Medical record reviadmitted 4/7/16 wit Cerebral Infarction Artery Occlusion w Aphasia, Dementia Disorder-Depressiv Major Depressive I Reflux Disease, Hy Hypokalemia,	Arrhythmia, Diabetes Mellitus astroesophageal Reflux Walking/Muscle Weakness, ght Total Hip Replacement. I record review revealed a Data Set (MDS) dated severe cognitive impairment behaviors exhibited. ew revealed Resident #37 was h diagnoses including due to Left Mid-Cerebral ith Right-sided Hemiplegia and pertension, Atherosclerosis, ercholesterolemia, Dysphagia, ye, Diabetes Mellitus Type II, with Cellulitis of the Right Continued medical record juarterly MDS dated 10/6/17 cognitive impairment with	F 6	300		

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Ri #3 fo pli Co su mi Mi 11 sp sta roi da ref po Nu PM "W Int the an left inta ge: late 11/Re	s room. Continued 7 was transferred 7 was transferred 7 was transferred 7 medical evaluation accement in a psycontinued review restained a slight did-forearm. Redical record review (2/17 at 6:20 AM itting and making aff when he learned of the medical side of the medical side of the medical respectively review hanother residered to the arm for not getting arm for	attempting to take him toward direview revealed Resident direview revealed Resident direview revealed Resident on, clearance, and possible chiatric facility. Evealed Resident #11 discoloration to the left direvealed Resident #37, was obscene gestures toward direct direvealed Resident #37 direct direct work of a Nurse's Note 10 PM revealed Resident #37 direct direct work of a Nurse's Note 10 PM revealed Resident #37 direct direct work of the direct dire	F 6	00	

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NAME OF PROVIDER OR SUPPLIER NORTHSIDE HEALTH CARE NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 202 EAST MTCS ROAD			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
erview with the E 30/17 at 1:45 Pl sident #37 was ting a roommate ntinued interview vent abusive be vards Resident # eresident has the glect, misapproperation as a texploitation as a texploitation as poral punishment physical or che at the resident's sed on facility properation of ident (#37) of 37 erfindings includation, dated wiew of facility proportion, dated	Director of Nursing (DON) on M in her office confirmed triggered by the possibility of e and slapped Resident #11. In woonfirmed the facility failed to chaviors of Resident #37 #11. In operiation/Exploitation The right to be free from abuse, oriation of resident property, defined in this subpart. This limited to freedom from the interestraint not required to medical symptoms. The interestraint not required to medical symptoms. The interestraint in the record ew, the facility failed to prevent of controlled medications for 1 to residents reviewed. The resident property means the end of resident property means the end of the resident's exploitation, or wrongful anent use of a resident's exploitation occurs an		1. a. LPN #4 was to 11/2/17. She of any hours from clocked out or of 11/1/17. LP presented to the nursing on 11/1/15. Resident #37 of for any advers were found. R. Responsible P. Doctor were b. 11/1/17. 2. DON and ADON comp. audit of 200/300 wing m. include narcotics that L. access to on 11/1/17. 3. All nursing staff was reappropriate handling an of medications policy st. 11/1/17. New employee educated on same policy prior to administering m. 4. DON or designee will c. audits of the resident's mensure that they have be administered per order. discrepancies will be verified that they have be administered per order. discrepancies will be verified to make the conducted on 5 medications. The conducted on 5 medications are sidents 2x a week for random thereafter to ensure that they have be administered per order. discrepancies will be verified to conducted on 5 medications. The conducted on 5 medications are sidents 2x a week for random thereafter to ensure that they have be administered per order. Any finding the compliance. Any finding the compliance. Any finding the compliance. Any finding the compliance and finding the compliance. Any finding the compliance is the compliance and finding the compliance. Any finding the conducted on 5 medications.	did not work in the time she in the morning N #4 was also be board of 3/17. 3/	11/2/17 11/1/17 11/1/17 11/1/17	
	DEFICIENCIES DRRECTION PIDER OR SUPPLIER HEALTH CARE I SUMMARY STA (EACH DEFICIENCE REGULATORY OR I Intinued From particulation and to act out. Perview with the II 30/17 at 1:45 PI sident #37 was atting a roommate retinued interview ret	HEALTH CARE NURSING AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Intinued From page 11 In to act out. Perview with the Director of Nursing (DON) on 30/17 at 1:45 PM in her office confirmed sident #37 was triggered by the possibility of thing a roommate and slapped Resident #11. Intinued interview confirmed the facility failed to event abusive behaviors of Resident #37 vards Resident #11. The from Misappropriation/Exploitation R(s): 483.12 Be resident has the right to be free from abuse, glect, misappropriation of resident property, dexploitation as defined in this subpart. This ludes but is not limited to freedom from poral punishment, involuntary seclusion and a physical or chemical restraint not required to the tesident's medical symptoms. S REQUIREMENT is not met as evidenced	DEFICIENCIES DRRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 445373 (X2) MULTI A BUILDIT B WING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Intinued From page 11 In to act out. Perview with the Director of Nursing (DON) on 30/17 at 1:45 PM in her office confirmed sident #37 was triggered by the possibility of ting a roommate and slapped Resident #11. Intinued interview confirmed the facility failed to event abusive behaviors of Resident #37 vards Resident #11. Per from Misappropriation/Exploitation R(s): 483.12 B 33.12 B resident has the right to be free from abuse, glect, misappropriation of resident property, and exploitation as defined in this subpart. This ludes but is not limited to freedom from poral punishment, involuntary seclusion and to physical or chemical restraint not required to at the resident's medical symptoms. In the resident's medical symptoms. In the second of facility policy review, medical recording its medical symptoms. In the resident's medical symptoms. SREQUIREMENT is not met as evidenced as seed on facility policy review, medical recording its medical symptoms. In the resident's medical facility failed to prevent suppropriation of controlled medications for 1 ident (#37) of 37 residents reviewed. Be findings included: Wiew of facility policy, Abuse, Neglect, soloitation, dated 11/27/16, revealed wisappropriation of resident property means observed the resident's propert	A A BUILDING BOOLDING BUILDING BUILDING BOOLDING BUILDING BOOLDING BUILDING BOOLDING BUILDING BOOLDING BUILDIN	DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIAN NUMBER 445373 A BUILDING A BUILDING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Third act out, enview with the Director of Nursing (DON) on 30/17 at 1:45 PM in her office confirmed sident #37 was triggered by the possibility of ting a roommate and slapped Resident #31 intinued interview confirmed the facility failed to went abusive behaviors of Resident #37 was from Misappropriation of resident property, a resident has the right to be free from abuse, plect, misappropriation of resident property, of the provision of physical or chemical restraint not required to at the resident's medical symptoms as REQUIREMENT is not met as evidenced used on facility policy review, medical record lew, and interview, the facility failed to prevent appropriation of controlled medications for 1 ident (#37) of 37 residents reviewed. Findings included: Wiew of facility policy, Abuse, Neglect, solitation, dated 11/27/16, revealed witsappropriation of resident property means beterate misplacement, exploitation, or wrongful appracy or permanent use of a resident's medications, or wrongful appracy or permanent use of a resident's medication of resident property means beterate misplacement, exploitation, or wrongful appracy or permanent use of a resident's medication of resident property means beterate misplacement, exploitation, or wrongful appracy or permanent use of a resident's medication of resident property means beterate misplacement, exploitation, or wrongful appracy or permanent use of a resident's medication's endities and the property means beterate misplacement, exploitation, or wrongful appracy or permanent use of a resident's medication of resident property means beterate misplacement, exploitation, or wrongful appracy or permanent use of a resident's medication of resident property means beterate misplacement, exploitation, or wrongful appracy or permanent use of a resident's medication of resident p	

PRINTED: 12/05/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			RPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		445373	B, WING		1	1/30/2017
	PROVIDER OR SUPPLIER	NURSING AND REHABILITATION	С	STREET ADDRESS, CITY, STATE, ZIP CC 202 EAST MTCS ROAD MURFREESBORO, TN 37130	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Policy, effective 11/2 will have safeguard diversion, or accide discrepancies that reported immediate and the Pharmacy; detailing the discreit; and names of all the discrepancy was the area until discreported as unreso Medical record reviadmitted to the faci including Cerebrova Hemiplegia, Aphas Hypertension, Gast Seizures, and Arter Disease. Medical record reviadministration Record reviadministration Record reviadministration Record reviadministration Record resign-Out Record resign-Out Record resign-Out Record resigned out and night. Review of the facility narcotic sign-out shad the signature (LPN) #4 as but also had the signature of the facility narcotic sign-out shad the signature of the facility narcotic signature of the facility narcotic signature of the facility narcotic sign-out shad the signature of the f	odicy, Controlled Medication (28/17 revealed "The facility is in place to prevent loss, ental exposureAny cannot be resolved must be ely: notify the DON immediately complete an investigation pancy; steps taken to resolve licensed staff working when is notedStaff may not leave epancies are resolved or lived discrepancies" ew revealed Resident #37 was lity on 4/7/16 with diagnoses ascular Accident with Right ia, Diabetes Mellitus, roesophageal Reflux Disease, iosclerotic Cardiovascular ew of the Quarterly Minimum ted 10/6/17 revealed Resident by impaired cognitively. ew of the October Medication ord (MAR) and Narcotic vealed on 10/30/17 and tianxiety) 0.5 milligrams (mg) di 0.25 mg were wasted each by investigation revealed the eet for Ativan for Resident administering the medication nature of Registered Nurse ing/confirming the wasting of	F 60			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	445373	B WING		11/30/2017	
NAME OF PROVIDER OR SUPPLIER NORTHSIDE HEALTH CARE N	IURSING AND REHABILITATION	2	TREET ADDRESS, CITY, STATE, ZIP CODE 02 EAST MTCS ROAD IURFREESBORO, TN 37130		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLET	ION
Continued review reappear to be that of she denied it was he laterview with the D Assistant Director of at 1:50 PM in their cout Ativan on 10/30/2 Continued interview signed out was 0.5 mg so 0.25 mg was interview revealed to observing and confict to be RN #2 but the not her regular signarevealed RN #2 was denied it was her signal DON confirmed the misappropriation of Reporting of Alleged SS=D CFR(s): 483.12(c)(1) S483.12(c)(1) Ensurinvolving abuse, negmistreatment, include source and misapprare reported immed hours after the allegate that cause the allegate serious bodily injury the events that cause	irector of Nursing (DON) and f Nursing (ADON) on 11/30/17 office revealed LPN #4 signed (17 and again on 10/31/17. The revealed the dose of Ativan and and the order was for 0.25 wasted each night. Further the signature of the nurse raming the wastage appeared DON and ADON said it was ature. Continued interview is interviewed and categorically gnature. Further interview the facility failed to prevent medications. If Violations (14) was attributed to prevent medications of abuse, or mistreatment, the facility failed to prevent medications (15) and the facility failed to prevent medications (16) and facility failed to prevent medications (17) and facility failed to prevent medications (18) and facility failed to prevent medications (19) and failed to prevent medications (1	F 602			
	sult in serious bodily injury, to the facility and to other				

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STATEME		(X1) PROVIDER/SUPPLIER/CLIA			FO	RM APPROV
THE PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3)	OATE SURVEY
NAME OF	PROVIDER OR SUPPLIER	445373	B. WING		- 1	
			Is	TREET ADDRESS OFFI	1	1/30/2017
(X4) ID		URSING AND REHABILITATION	C 2	TREET ADDRESS, CITY, STATE, ZIP CODE 02 EAST MTCS ROAD URFREESBORO, TN 37130		
PRÉFIX TAG	(EACH DEFICIENCY REGULATORY OR LS	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRICATION OF THE APPRICA		(X5) COMPLETIO DATE
F 609	officials (including to adult protective servi for jurisdiction in long accordance with Stat	the State Survey Agency and ces where state law provides interm care facilities) in e law through established	F 609	609		
	§483.12(c)(4) Report investigations to the adesignated represent accordance with State Survey Agency, within incident, and if the alle	the results of all administrator or his or her ative and to other officials in a law, including to the State 5 working days of the		 Resident #11 and #37 RESPONSIBLE PARTY and were notified of the event. Residents were assessed and injury found. Administrator reviewed pr incident reports to ensure they 	no oviene	11/1/17
t n ir	This REQUIREMENT by: Based on facility policy eview, review of an In- nterview, the facility facesident to resident ab-	is not met as evidenced y review, medical record		3. Management staff was re- educated on the regulation and timely reporting on 12/14/17. staff will be re-educated on pro- verbal notification to ensure accurate description of events by 12/29/17.	I All oper	12/14/17 12/29/17
Re Ex abb Off Su est	the findings included: eview of facility policy, exploitation, effective 1/2. Report allegations or buseimmediately to [ifficials in accordance varvey and Certification tablished procedures	Abuse, Neglect, 27/2016 revealed suspected the AdministratorOther with State LawState agency through		4. A member of the interdiscip, team will review event notes fi days a week to ensure documentation matches what is verbally reported. Weekly audi all incidents will be reviewed for any trends and needed education 6 weeks then monthly thereafter All audits will be brought to QA for review.	its of or	01/26/18
diag Pul with Ger Sch	gnoses including Chro monary Disease, Asth nout Behaviors and wit neralized Anxiety Diso izophrenia, Major Dep illation, Hypertension,	omitted 6/9/17 with onic Obstructive ma, Vascular Dementia				

PRINTED: 12/05/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391. (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING 445373 B. WING-11/30/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 202 EAST MTCS ROAD NORTHSIDE HEALTH CARE NURSING AND REHABILITATION C MURFREESBORO, TN 37130 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES 1D (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 609 F 609 Continued From page 15 Disease, Cardiac Arrhythmia, Diabetes Mellitus Type II. Anemia, Gastroesophageal Reflux Disease, Difficulty Walking/Muscle Weakness, and status-post Right Total Hip Replacement. Continued medical record review revealed a quarterly Minimum Data Set (MDS) dated 11/10/17 revealed severe cognitive impairment with no moods or behaviors exhibited. Medical record review revealed Resident #37 was admitted 4/7/16 with diagnoses including Cerebral Infarction due to Left Mid-Cerebral Artery Occlusion with Right-sided Hemiplegia and Aphasia, Dementia, Schizoaffective Disorder-Depressive Type, Anxiety Disorder, Major Depressive Disorder, Gastroesophageal Reflux Disease, Hypertension, Atherosclerosis, Hypokalemia, Hypercholesterolemia, Dysphagia, Low Vision Right Eye, Diabetes Mellitus Type II, and Lymphedema with Cellulitis of the Right Lower Extremetiy. Continued medical record review revealed a quarterly MDS dated 10/6/17 revealed moderate cognitive impairment with poor decision making. Review of an Investigation Summary dated 11/6/17 at 10:00 AM revealed, "... Altercation was observed by employee #1 [Licensed Practical Nurse (LPN) #3] at around 10:00 AM on 11/6/17..." Interview with Certified Nurse Aide (CNA) #2 on

11/30/17 at 10:40 AM in the 300 hall revealed Resident #37 hit and made an obscene gesture to Resident #11 on the left arm for not getting out of his way. Continued interview revealed CNA #2 stated the event happened on 11/6/17 at around

10:00 AM.

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: TN7506

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLI A BUILDING		(X3) DATE SURVEY COMPLETED		
		445373	B WING		11/	11/30/2017	
NAME OF PROVIDER OR SUPPLIER NORTHSIDE HEALTH CARE NURSING AND REHABILITATION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			20	TREET ADDRESS, CITY, STATE, ZIP CODE 12 EAST MTCS ROAD 1URFREESBORO, TN 37130 PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE	
F 641	the 300 hall revealed about the possibility "acted-out." Continustated Resident #33 11/6/17 close to 103 Interview with the S 11/30/17 at 1:35 PM Resident #37 was ugetting a roommate him to act out. Conevent occurred on 11/30/17 at 1:45 PM event between Res 11/6/17 around 10:0 timely report the occuntil 11/7/17 at 11:1 Accuracy of Assess CFR(s): 483.20(g) §483.20(g) Accuracy The assessment more resident's status. This REQUIREMENT by: Based on medical the facility failed to a resident (#44) of 37. The findings include Medical record reviewed.	#1 on 11/30/17 at 10:45 AM in ad Resident #37 was upset of getting a roommate and used interview revealed LPN #1 resident #11 on 00 AM. Hocial Services Director on an in her office revealed upset at the possibility of and this "probably triggered" attinued interview revealed the 11/6/17 around 10:00 AM. Historical Services Director on an in her office revealed the 11/6/17 around 10:00 AM. Historical Services Director on an in her office revealed the 11/6/17 around 10:00 AM. Historical Services Director on and interview revealed the 11/6/17 around 10:00 AM. Historical Services Director on and interview and interview and interview, accurately assess vision for 1 aresidents reviewed. Historical Services Director on and interview, accurately assess vision for 1 aresidents reviewed. Historical Services Director on and interview, accurately assess vision for 1 aresidents reviewed. Historical Services Director on and interview, accurately assess vision for 1 aresidents reviewed.	F 641	I. MDS for Resident #9 was comby MDS to reflect that the resident's vision is severely impaired/blind on 11/30/17. 2. A 100% audit of current resistand latest MDS vision assess to ensure accurate coding on 12/14/17. 3. The administrator provided a Coaching Form to the Social Service Director on the RAI manual standards for vision on 12/13/17. 4. MDS coordinator to audit ra (at least 3) Social Services completed sections prior to submitting to ensure accurat coding weekly for 6 weeks. findings of noncompliance was presented to the QAPI common for review.	dents sment a t coding ndom e Any vill be	11/30/17 12/14/17 12/13/17 01/26/18	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/05/2017

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NC	0.0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUE	TIPLE	CONSTRUCTION	(X3) DATE SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER				COI	MPLETED
		445373	B WING			11	/30/2017
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
NORTHS	IDE HEALTH CARE N	IURSING AND REHABILITATION	С		ZEAST MTCS ROAD JRFREESBORO, TN 37130		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 641	Continued From pa		Fé	541			
	Medical record revi Data Set (MDS) da Resident #9's vision	ew of the Quarterly Minimum ted 10/24/17 revealed n was adequate					
	at 8:42 AM in her of vision MDS assess Worker was respon assessment on the confirmed vision was	IDS Coordinator on 11/30/17 Iffice regarding the 10/24/17 ment revealed the Social sible for the vision MDS. Further interview as inaccurately assessed as f severely impaired/blind.		10 C			
5.075	8:47 AM in the MDS responsible for the MDS Further intervishould have been cand the MDS was r	ocial Worker on 11/30/17 at Soffice confirmed she was vision assessment on the lew confirmed Resident #9 classified as highly impaired lot accurate.	F.	375			
	Quality of Life CFR(s): 483.24		1. (373			
	applies to all care a residents. Each residents. Each residents. Each residents are another highest practical psychosocial well-bresident's comprehend care. This REQUIREMENT by: Based on observative record review, the first residents and the second review.	indamental principle that nd services provided to facility sident must receive and the	10	The second control of			** (**)
	devices in the dining	g room.		ĺ			

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Facility ID: TN7506

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING		COMPLETED			
		445373	B WING		11/30/2017	
NORTHSIDE HEALTH CARE NURSING AND REHABILITATION C (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CONTROL (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTIVE A				BE	(X5) COMPLETION DATE	
F 675	room revealed Res assistance with metable in a broda chawheelchair). Conting resident was position was being assisted Nurse Aide (CNA). Interview with the Coin the dining room of positioned in a 45 diassisted with eating Continued interview. Resident #3 would during meals, or hit Continued interview correctly position Rewith eating. Interview with the Aid 11/30/17 at 1:30 PM had been trained or eating during meals confirmed the facilit Resident #3 while a Quality of Care CFR(s): 483.25 § 483.25 Quality of Quality of care is a fapplies to all treatmost facility residents. Bassessment of a residents received the same confirmed the facility residents. Bassessment of a residents received the same confirmed the facility residents.	ed: 29/17 at 8:20 AM in the dining ident #3 was dependent for als and seated at a restorative air (specialized large nued observation revealed the aned in a 45 degree angle and with eating by a Certified NA #3 on 11/29/17 at 8:20 AM confirmed Resident #3 was egree angle while being the breakfast meal. Trevealed the CNA stated ary to get out of the chair staff that assisted her. Trevealed the facility failed to esident #3 during assistance assistant Director of Nursing on I in her office confirmed staff in how to assist residents with Continued interview y failed to accurately position ssisting with eating.	F 684	 Resident #3 was sat up into the proper position for eating durin meals starting on 11/30/17. 100% audit of all residents in mobility devices during dining was done on 12/1/17. All nursing staff will be re-educ on Resident Rights and Dining Services policies by 12/29/17. I Employees will be educated up hire before entering patient care areas. DON, ADON, and other design do 2x weekly audits of dining a and dining practices for 6 week Any findings of noncompliance be presented to the QAPI comm for review. 	times cated New on e nee to nreas s. e will	11/30/17 12/1/17 12/29/17 01/26/18

2085

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1, ,	DATE SURVEY COMPLETED
		445373	B WING_			11/30/2017
	PROVIDER OR SUPPLIER	IURSING AND REHABILITATION	С	STREET ADDRESS, CITY, STATE, ZIP C 202 EAST MTCS ROAD MURFREESBORO, TN 37130	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 684	care plan, and the rathis REQUIREMENt by: Based on review of review, review of a interview, the facility were administered and narcotics were policy for 6 resident of 37 residents review. The findings included Review of facility poems and Medication 11/28/17, revealed administered by lice personnel acting with as per the Physician choices and activities consistent with the procession of medical interview administration of medical interviews administration of medical interviews and activities consistent with the processional standard to professional standard to profession, or accident discrepancies that coreported immediately and the Pharmacy; of the standard to profession, or accident and the Pharmacy; of the standard to profession the profession to the profession, or accident discrepancies that coreported immediately and the Pharmacy; of the standard to profession the profession that the pharmacy; of the profession that the pharmacy is the pharmacy in the pharmacy in the pharmacy is the pharmacy in th	ehensive person-centered esidents' choices. NT is not met as evidenced f facility policy, medical record facility investigation, and y failed to ensure medications according to Physician Orders wasted according to facility s (#6, #8, #15, #24, #35, #37) ewed. Alicy, Preventing Medication on Administration, effective medications may only be ensed medical or nursing thin the scope of their license in order honoring resident es as much as possible, be son centered explanMedication error dor identified preparation or edications or biologicals which exist the prescription order; specifications regarding ministration; accepted reds and principals which apply viding services"	F 68	1. a. LPN #4 was tern 11/2/17. She did hours from the tolocked out on tolocked out of the and Doctors were 11/1/17. 2. DON and ADON complete of 200/300 wing medicart narcotics that LPN #4 had 11/1/17. 3. All nursing staff was re-early appropriate handling and demedications policy starting. New employees are now estame policy upon hire price administering medications. 4. DON or designee will contain audits of the resident's mean consure that they have been per order. Any discrepance verified with MAR docum. These audits will be conducted out of the treatment of the compliance. Any findings noncompliance will be preceded out of the prec	d not work any ime she he morning of 4 was also board of /17. 3,15,24,35, and d for any none were eir families re notified on ed 100% audit to include access to on ducated on dispensing of g on 11/1/17. ducated on or to a diministered ies will be nentation. Include on 5 ek for 6 weeks ensure s of esented to the	11/2/17 11/1/17 11/1/17

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		T WEBTOTHE OF TATOLO			7. 0330-0331		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		445373	B. WING	William Company of the Company of th	11/30/2017		
	PROVIDER OR SUPPLIER SIDE HEALTH CARE N	IURSING AND REHABILITATION	С	STREET ADDRESS, CITY, STATE, ZIP 202 EAST MTCS ROAD MURFREESBORO, TN 37130			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 684	the discrepancy was the area until discre reported as unresola Medical record revie admitted to the facili including Atheroscle Hypertension, Gastr and Crohn's Disease Medical record revie Data Set (MDS) reve on the Brief Interview indicating moderate Medical record revie Administration Recorevealed it was docu administered Tramac at 9:00 PM on 10/30 Nurse (LPN) #4. Medical record review admitted to the facilit including End Stage Hypertension, Corona	licensed staff working when a notedStaff may not leave pancies are resolved or wed discrepancies" Ew revealed Resident #6 was aty on 5/24/16 with diagnoses rotic Cardiovascular Disease, oesophageal Reflux Disease, oesop	F 68	34			
	Vein Thrombosis. Medical record review dated 11/11/17 revea on the BIMS indicatin and able to make her Medical record review revealed documentation.	v of the Quarterly MDS led Resident #8 scored 15 g she was alert, oriented, needs known.					

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12/15/2017 18:09

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMEN'	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CONSTRUCTION	(X3)	DATE SURVEY
	OF CORRECTION	DENTIFICATION NUMBER.	1 '	IG		COMPLETED
		445373	B. WING			11/30/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
NORTHS	SIDE HEALTH CARE N	IURSING AND REHABILITATION	С	202 EAST MTCS ROAD MURFREESBORO, TN 37130		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	Continued From pa	ge 21	F 68	4		
	admitted to the facilincluding Diabetes I	ew revealed Resident #15 was lity on 3/3/16 with diagnoses Mellitus, Paroxysmal Atrial tive Sleep Apnea, and				i i
	dated 9/2/17 reveal	ew of the Quarterly MDS ed Resident #15 scored 10 on g she had moderate cognitive				
	revealed documenta	ew of the October MAR ation Resident #15 was estatin 20 mg at 9:00 PM on				
	admitted to the facilincluding Congestive	ew revealed Resident #24 was ity on 5/3/99 with diagnoses e Heart Failure, Seizures, lypertension, and Benign ny.				
		ew of the Quarterly MDS led Resident #24 was ognitively.				
21	revealed documenta administered a Fent	ew of the October MAR ation Resident #24 was anyl (pain) patch 50 r to be changed every 3 days				
	admitted to the facili	w revealed Resident #35 was ty on 7/20/15 with diagnoses by Diabetes Mellitus, and Pulmonary Disease.				
	Medical record revie	w of the Quarterly MDS				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	(X:	(X3) DATE SURVEY COMPLETED		
	445373	B WING			11/30/2017		
NAME OF PROVIDER OR SUPPLIER NORTHSIDE HEALTH CARE N	URSING AND REHABILITATION	С	STREET ADDRESS, CITY, STATE, ZIP (202 EAST MTCS ROAD MURFREESBORO, TN 37130	CODE	X		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIAT	(X5) COMPLETION TE DATE		
Medical record revier administered Neuro on 10/31/17. Medical record revier admitted to the facility including Cerebroval Hemiplegia, Aphasis Hypertension, Gastri Seizures, and Arteri Disease. Medical record revier administered Atoroval 10/6/17 reveal moderately impaired Medical record revier revealed documents administered Atoroval 10/31/17. Continued Narcotic Sign-Out Rand 10/31/17 Ativan signed out and 0.25. Review of the facility spoke with the Direct morning of 10/31/17 was not administering PM - 7:00 AM shift the DON conducted due to be administer PM - 7:00 AM shift or revealed the staff standministered on 10/31/15 administered o	aled Resident #35 was ognitively. ew of the October MAR ation Resident #35 was ontin (pain) 100 mg at 9:00 PM ew revealed Resident #37 was ity on 4/7/16 with diagnoses ascular Accident with Right a, Diabetes Mellitus, roesophageal Reflux Disease, osclerotic Cardiovascular ew of the Quarterly MDS aled Resident #37 was	F6	84				

12/15/2017 18:10

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	445373	B WING_		11/30/2017		
NAME OF PROVIDER OR SUPPLIER NORTHSIDE HEALTH CARE N	NURSING AND REHABILITATION	С	STREET ADDRESS, CITY, STATE, ZIF 202 EAST MTCS ROAD MURFREESBORO, TN 37130	PCODE		
PREFIX (EACH DEFICIENCY	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
recounted the medical discrepancies with a #8, #15, #24, #35, a revealed the medical 11/1/17 as it was on medications were in revealed the resider received their medical review revealed the Ativan for Resident #4 as administering the signature of RN the wasting of 0.25 and 10/31/17. Continued signature did not ap when questioned shall review of a written and 11/1/15 revealed at for his medications. CNA #7 went to the asleep with the car in Review of a written and Director of Nursing (revealed one resider pain medications due (LPN #4) made her for medications she was review revealed anot to ask for her medical were due and the nursie specific their medications. Review of the facility Review of the facility	review revealed the DON cations on 11/1/17 and found medications for Residents #6, and #37. Further review ation count was the same on 10/31/17, indicating the ot given. Continued review has who had discrepancies cations from LPN #4. Further narcotic sign-out sheet for #37 had the signature of LPN the medication but also had #2 as observing/confirming mg of Ativan on 10/30/17 and I review revealed the pear to be that of RN #2 and e denied it was her signature. Statement from CNA #7 dated 10:15 PM a resident asked Continued review revealed car of LPN #4 and found her unning statement by the Assistant ADON) dated 10/31/17 and stated she had to ask for ring the night and the nurse feel insecure about the statement stated she had ations quite awhile after they rese (LPN #4) appeared we revealed this resident was residents who could not ask	F 68	4			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		445373	B WING			11/30/2017
	PROVIDER OR SUPPLIER	NURSING AND REHABILITATION	С	STREET ADDRESS, CITY, ST. 202 EAST MTCS ROAD MURFREESBORO, TN	ATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ID TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE
	administered. Cont DON and ADON to she was terminated 1:50 PM in their office CNAs came to ther #4 was administering that point the DON would be administered and the of the night. When a medications she would the medications she would be administered and the of the night. When a medications she would be about them. At one point of CNAs had to knock because she was another count of medications were documed medications were stindicating they were DON and ADON viet from the night of 10 be absent from the level as in a camera beauty shop. They as sleeping at the nurse called LPN #4; infort told her she was term DON confirmed LPN as being administered In summary, on the	commented them as being tinued review revealed the elephoned LPN #4 to notify her d. DON and ADON on 11/30/17 at fice revealed on 10/31/17 them to say they did not think LPN and medications to residents. At counted the medications that ered on the 7:00 PM - 7:00 AM and of 11/1/17 the staff again dications were not they couldn't find LPN #4 most residents would ask for ould say she had already given during the night one of the conthe car window of LPN #4 asleep in the car. The DON did edications on 11/1/17 and counts were correct. Sporadic ented as administered but the still in the blister packs, and administered. Both the ewed the video surveillance with the video	F 6	384		
	residents as being a	ocumented medications for 6 administered when they were				

PRINTED: 12/05/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			ISTRUCTION		(X3) DATE SURVEY COMPLETED	
		445373	B. WING				11/30/2017	
	SUMMARY STA (EACH DEFICIENCY	URSING AND REHABILITATION OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG	202 EA MURFI	ST MTCS F REESBOF PROVIC (EACH CO	, CITY, STATE, ZIP CODE. ROAD RO, TN 37130 DER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD FERENCED TO THE APPROPED DEFICIENCY)	BĒ	(X5) COMPLETION DATE
F 804 SS=D	signed out 2 narcoti and signed the name the video surveilland. #4 missing from the as well as sleeping reported they had to up to give medication. Nutritive Value/Appe CFR(s): 483.60(d) (1) \$483.60(d) (1) Food conserve nutritive value/Appe CFR(s): 483.60(d) (2) Food attractive, and at a stemperature. This REQUIREMENT by: Based on observation dietary department of pureed textured food comingling of the foomeals observed. The findings include Observation on 11/2 resident mid-day medietary department, Manager (CDM) preseveral resident tray trayline. Further obseham and beans, and	On those two nights LPN #4 cs; wasted part of the tablet; e of another nurse. Review of ce for 10/31/17 revealed LPN building for periods of time at the nurses' station. Staff go out to her car to wake her ons to residents. ear, Palatable/Prefer Temp)(2) d drink wes and the facility provides- prepared by methods that alue, flavor, and appearance; and drink that is palatable, eafe and appetizing T is not met as evidenced on and interview, the facility ailed to prepare and serve d in a manner to prevent od on the plate for 1 of 4	F &	304	add im 2. 100 pur 11. 3. Dio on sta 4. CE a v fin be	areed consistency was dressed by CDM amediately on 11/28/17. 10% audit of all residents areed diet was completed /28/17. 1999 are consistency aring on 11/28/17. 1999 and to audit pureed meals week for 6 weeks. Any adings of noncompliance presented to the QAPI ammittee for review.	on ed y 5 2x	11/28/17 11/28/17 11/28/17 01/26/18

Facility ID: TN7506

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	445373	B. WING	Pt	11/30/2017	
NAME OF PROVIDER OR SUPPLIER NORTHSIDE HEALTH CARE NURSING AND REHABILITATION		С	STREET ADDRESS, CITY, STATE, ZIP CODE 202 EAST MTCS ROAD MURFREESBORO, TN 37130	,	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIC X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	DBE COMPLETION	
revealed the pureed cabbage ran together linterview with the Cl in the dietary department fextured food was verified the plate. Further into	ge 26 Indual resident's plates I ham and beans and pureed per and comingled on the plate. DM on 11/28/17 at 11:35 AM Iment confirmed the pureed pery runny and co-mingled on perview confirmed the pureed and to the proper standard"	F8	04		